(COMPANY NAME)

Outline of Medicare Supplement Coverage - Cover Page:

Benefit Plan(s)__ (Insert letter(s) of plan(s) being offered)

These charts show the benefits included in each of the standard Medicare supplement plans. Every company must make available Plan "A". Some plans may not be available in your state.

BASIC BENEFITS FOR PLANS A through J:

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical expenses: Part B coinsurance (twenty (20) percent of Medicare-approved expenses), or copayments for hospital outpatient services.

Blood: First three (3) pints of blood each year.

*Plans F and J also have an option called a high deductible Plan F and a high deductible Plan J. These high deductible plans pay the same benefits as Plans F and J after one has paid a calendar year $1690 deductible. Benefits from high deductible Plans F and J will not begin until out-of-pocket expenses exceed $1690. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

A	B	C	D	E	F	G	H	I	J
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible			Part B Deductible				Part B Deductible
					Part B Excess (100%)	Part B Excess (100%)		Part B Excess (100%)	Part B Excess (100%)
		Foreign Travel Emer-gency	Foreign Travel Emer-gency	Foreign Travel Emer-gency	Foreign Travel Emer-gency	Foreign Travel Emer-gency	Foreign Travel Emer-gency	Foreign Travel Emer-gency	Foreign Travel Emer-gency
			At-home Recovery			At-home Recovery		At-home Recovery	At-home Recovery
				Preventive Care NOT covered by Medicare					Preventive Care NOT covered by Medicare

COMPANY NAME

Outline of Medicare Supplement- Coverage Cover Page 2

Basic Benefits for Plans K and L include similar services as plans A – J, but cost sharing for the basic benefits is at different levels.

J	K**	L**
Basic Benefits	100% of Part A Hospitalization plus coverage for 365 Days after Medicare Benefits End 50% Hospice cost-sharing 50% of Medicare-eligible expenses for the first three pints of blood 50% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services	100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End 75% Hospice cost-sharing 75% of Medicare-eligible expenses for the first three pints of blood 75% Part B Coinsurance, except 100%Coinsurance for Part B Preventive Services
Skilled Nursing Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance
Part A Deductible	50% Part A Deductible	75% Part A Deductible
Part B Deductible		
Part B Excess (100%)		
Foreign Travel Emergency		
At-Home Recovery		
Preventive Care NOT covered by Medicare		
	$[4000] Out of Pocket Annual Limit***	$[2000] Out of Pocket Annual Limit***

**Plans K and L provide for different cost-sharing for items and services other than Plans A – J. Once you reach the annual limit, the plan pays one hundred percent (100%) of the Medicare copayments, coinsurance, and deductibles for the remainder of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called "Excess Charges". You will be responsible for paying excess charges.

***The out-of-pocket annual limit shall increase each year for inflation.

See Outlines of Coverage for details and exceptions.

1. PREMIUM INFORMATION (Boldface Type)

We (insert issuer's name) can only raise your premium if we raise the premium for all policies like yours in this state. (If the premium is based on the increasing age of the insured, include information specifying when premiums will change).

2. DISCLOSURES (Boldface Type)

Use this outline to compare benefits and premiums among policies.

3. READ YOUR POLICY VERY CAREFULLY (Boldface Type)

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

4. RIGHT TO RETURN POLICY (Boldface Type)

If you find that you are not satisfied with your policy, you may return it to (insert issuer's address). If you send the policy back to us within thirty (30) days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

5. POLICY REPLACEMENT (Boldface Type)

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

6. NOTICE (Boldface Type)

This policy may not fully cover all of your medical costs.

a. (for agents)
Neither (insert insurer's name) nor its agents are connected with Medicare.

b. (for direct response insurers:)
(insert insurer's name) is not connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security office or consult "Medicare & You" for more details.

7. COMPLETE ANSWERS ARE VERY IMPORTANT (Boldface Type)

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. (If the policy or certificate is guaranteed issue, this paragraph need not appear.)

Review the application carefully before you sign it. Be certain that all information has been recorded properly.

(Include for each plan prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments, and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in the charts below. More than four (4) plans shall not be shown on one (1) chart. For purposes of illustration, charts for each plan are included in this administrative regulation. An issuer may use additional benefit plan designations on these charts pursuant to Section 7(4) of this administrative regulation.)

(Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the executive director.)

PLAN A
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[912]	$0	$[912] (Part A deductible)
61st thru 90th day	All but $[228] a day	$[228] a day	$0
91st day and after while using 60 lifetime reserve days	All but $[456] a day	$[456] a day	$0
91st day and after once lifetime reserve days are used - Additional 365 days	$0	100% of Medicare-eligible expenses	$0
91st day and after once lifetime reserve days are used - Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[114] a day	$0	Up to $[114] a day
101st day and after	$0	$0	All costs

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

PLAN A MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR			
*Once you have been billed $[110] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.			
SERVICES	**MEDICARE PAYS**	**PLAN PAYS**	**YOU PAY**
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First $[110] of Medicare-approved amounts*	$0	$0	$[110] (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (above Medicare approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[110] of Medicare-approved amounts*	$0	$0	$[110] (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
CLINICAL LABORATORY SERVICES [~~- BLOOD~~] TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN A PARTS A & B			
SERVICES	**MEDICARE PAYS**	**PLAN PAYS**	**YOU PAY**
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically-necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $[110] of Medicare-approved amounts*	$0	$0	$[110] (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

PLAN B
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[912]	$[912] (Part A deductible)	$0
61st thru 90th day	All but $[228] a day	$[228] a day	$0
91st day and after while using 60 lifetime reserve days	All but $[456] a day	$[456] a day	$0
91st day and after once lifetime reserve days are used – additional 365 days	$0	100% of Medicare-eligible expenses	$0
91st day and after once lifetime reserve days are used – beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amount	$0	$0
21st thru 100th day	All but $[114] a day	$0	Up to $[114] a day
101st day and after	$0	$0	All costs

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN B MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR			
*Once you have been billed $[110] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.			
SERVICES	**MEDICARE PAYS**	**PLAN PAYS**	**YOU PAY**
MEDICAL EXPENSES: IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[110] of Medicare-approved amounts*	$0	$0	$[110] (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $100 of Medicare-approved amounts*	$0	$0	$[110] (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
CLINICAL LABORATORY SERVICES TESTS FOR DIAGNOSTIC SERVICES	$100	$0	$0

PLAN B PARTS A & B			
SERVICES	**MEDICARE PAYS**	**PLAN PAYS**	**YOU PAY**
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically-necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $[110] of Medicare-approved amounts*	$0	$0	$[110] (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

PLAN C
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[912]	$[912] (Part A deductible)	$0
61st thru 90th day	All but $[228] a day	$[228] a day	$0
91st day and after while using 60 lifetime reserve days	All but $[456] a day	$[456] a day	$0
91st day and after once lifetime reserve days are used – Additional 365 days	$0	100% of Medicare-eligible expenses	$0
91st day and after once lifetime reserve days are used – Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[114] a day	Up to $[114] a day	$0
101st day and after	$0	$0	All costs

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for out patient drugs and inpatient respite care	$0	Balance

PLAN C **MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR**			
*Once you have been billed $[110] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.			
SERVICES	**MEDICARE PAYS**	**PLAN PAYS**	**YOU PAY**
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[110] of Medicare-approved amounts*	$0	$[110] (Part B deductible)	$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[110] of Medicare-approved amounts*	$0	$[110] (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
CLINICAL LABORATORY SERVICES TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN C PARTS A & B			
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically-necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $[110] of Medicare-approved amounts*	$0	$[110] (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0

PLAN C OTHER BENEFITS - NOT COVERED BY MEDICARE			
SERVICES	**MEDICARE PAYS**	**PLAN PAYS**	**YOU PAY**
FOREIGN TRAVEL-NOT COVERED BY MEDICARE Medically-necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN D
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[912]	$[912] (Part A deductible)	$0
61st thru 90th day	All but $[228] a day	$[228] a day	$0
91st day and after while using 60 lifetime reserve days	All but $[456] a day	$[456] a day	$0
91st day and after once lifetime reserve days are used - Additional 365 days	$0	100% of Medicare-eligible expenses	$0
91st day and after once lifetime reserve days are used - Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[114] a day	Up to $[114] a day	$0
101st day and after	$0	$0	All costs

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN D **MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR**			
*Once you have been billed $[110] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.			
SERVICES	**MEDICARE PAYS**	**PLAN PAYS**	**YOU PAY**
MEDICAL EXPENSES: IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[110]of Medicare-approved amounts*	$0	$0	$[110] (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (above Medicare-approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[110] of Medicare-approved amounts*	$0	$0	$[110] (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
CLINICAL LABORATORY SERVICES TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN D PARTS A & B			
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically-necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $[110] of Medicare-approved amounts*	$0	$0	$[110] (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
AT-HOME RECOVERY SERVICES - NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a home care treatment plan			
Benefit for each visit	$0	Actual charges to $40 a visit	Balance
Number of visits covered (must be received within 8 weeks of last Medicare-approved visit)	$0	Up to the # of Medicare-approved visits, not to exceed 7 each week	
Calendar year maximum	$0	$1,600	

PLAN D OTHER BENEFITS - NOT COVERED BY MEDICARE			
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically-necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN E MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD			
*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row. **NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.			
SERVICES	**MEDICARE PAYS**	**PLAN PAYS**	**YOU PAY**
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[912]	$[912] (Part A deductible)	$0
61st thru 90th day	All but $198 a day	$198 a day	$0
91st day and after while using 60 lifetime reserve days	All but $[456] a day	$[456] a day	$0
91st day and after once lifetime reserve days are used - Additional 365 days	$0	100% of Medicare-eligible expenses	$0
91st day and after once lifetime reserve days are used - Beyond the additional 365 days	$0	$0	All costs

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[114] a day	Up to $[114] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN E MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR			
*Once you have been billed $[110] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.			
SERVICES	**MEDICARE PAYS**	**PLAN PAYS**	**YOU PAY**
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[110] of Medicare-approved amounts*	$0	$0	$[110] (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (above Medicare approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[110] of Medicare-approved amounts*	$0	$0	$[110] (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN E PARTS A & B			
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically-necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $[110] of Medicare-approved amounts*	$0	$0	$[110] (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

PLAN E OTHER BENEFITS - NOT COVERED BY MEDICARE			
*Medicare benefits are subject to change. Please consult the latest Guide to Health Insurance for People with Medicare.			
SERVICES	**MEDICARE PAYS**	**PLAN PAYS**	**YOU PAY**
FOREIGN TRAVEL-NOT COVERED BY MEDICARE Medically-necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
***PREVENTIVE MEDICAL CARE BENEFIT-NOT COVERED BY MEDICARE** Annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare			
First $120 each calendar year	$0	$120	$0
Additional charges	$0	$0	All costs

PLAN F or HIGH DEDUCTIBLE PLAN F
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.
**This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $[1690] deductible. Benefits from the high deductible Plan F will not begin until after out-of-pocket expenses are $[1690]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductible for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1690 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $1690 DEDUCTIBLE** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[912]	$[912] (Part A deductible)	$0
61st thru 90th day	All but $[228] a day	$[228] a day	$0
91st day and after while using 60 lifetime reserve days	All but $[456] a day	$[456] a day	$0
91st day and after once lifetime reserve days are used – Additional 365 days	$0	100% of Medicare-eligible expenses	$0
91st day and after once lifetime reserve days are used – Beyond the additional 365 days	$0	$0	All costs

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1690 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $1690 DEDUCTIBLE** YOU PAY
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[114] a day	Up to $[114] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN F or HIGH DEDUCTIBLE PLAN F
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $[110] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.
**This deductible plan pays the same or offers the same benefits as Plan F after one has paid a calendar year $[1690] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $[1690]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1690 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $1690 DEDUCTIBLE** YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[110] of Medicare-approved amounts*	$0	$[110] (Part B deductible)	$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (above Medicare-approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $[110] of Medicare-approved amounts*	$0	$[110] (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN F or HIGH DEDUCTIBLE PLAN F PARTS A & B			
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically-necessary skilled care Services and medical supplies	100%	$0	$0
Durable medical equipment			
First $[110] of Medicare-approved amounts*	$0	$[110] (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0

PLAN F or HIGH DEDUCTIBLE PLAN F OTHER BENEFITS - NOT COVERED BY MEDICARE			
SERVICES	**MEDICARE PAYS**	**PLAN PAYS**	**YOU PAY**
FOREIGN TRAVEL-NOT COVERED BY MEDICARE Medically-necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN G
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[912]	$[912] (Part A deductible)	$0
61st thru 90th day	All but $[228] a day	$[228] a day	$0
91st day and after while using 60 lifetime reserve days	All but $[456] a day	$[456] a day	$0
91st day and after once lifetime reserve days are used - Additional 365 days	$0	100% of Medicare-eligible expenses	$0
91st day and after once lifetime reserve days are used - Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[114] a day	Up to $[114] a day	$0
101st day and after	$0	$0	All costs

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN G **MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR**			
*Once you have been billed $[110] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.			
SERVICES	**MEDICARE PAYS**	**PLAN PAYS**	**YOU PAY**
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[110] of Medicare-approved amounts*	$0	$0	$[110] (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (above Medicare approved amounts)	$0	80%	20%
BLOOD			
First 3 pints	$0	All costs	$0
Next $[110] of Medicare-approved amounts*	$0	$0	$[110] (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
CLINICAL LABORATORY SERVICES TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN G PARTS A & B			
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically-necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $[110] of Medicare-approved amounts*	$0	$0	$[110] (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
AT-HOME RECOVERY SERVICES-NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a home care treatment plan			
Benefit for each visit	$0	Actual charges to $40 a visit	Balance
Number of visits covered (must be received within 8 weeks of last Medicare-approved visit)	$0	Up to the # of Medicare-approved visits, not to exceed 7 each week	
Calendar year maximum	$0	$1,600	

PLAN G OTHER BENEFITS - NOT COVERED BY MEDICARE			
SERVICES	**MEDICARE PAYS**	**PLAN PAYS**	**YOU PAY**
FOREIGN TRAVEL-NOT COVERED BY MEDICARE Medically-necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN H MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD			
*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row. **NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.			
SERVICES	**MEDICARE PAYS**	**PLAN PAYS**	**YOU PAY**
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[912]	$[912] (Part A deductible)	$0
61st thru 90th day	All but $[228] a day	$[228] a day	$0
91st day and after while using 60 lifetime reserve days	All but $[456] a day	$[456] a day	$0
91st day and after once lifetime reserve days are used - Additional 365 days	$0	100% of Medicare-eligible expenses	$0
91st day and after once lifetime reserve days are used - Beyond the additional 365 days	$0	$0	All costs

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[114] a day	Up to $[114] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN H
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $[110] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[110] of Medicare-approved amounts*	$0	$0	$[110] (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0

PART B EXCESS CHARGES (above Medicare approved amounts)	$0	0%	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[110] of Medicare-approved amounts*	$0	$0	$[110] (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN H **PARTS A & B**			
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically-necessary skilled care services and medical supplies	100%	0	$0
Durable medical equipment			
First $[110] of Medicare-approved amounts*	$0	$0	$[110] (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

PLAN H **OTHER BENEFITS - NOT COVERED BY MEDICARE**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL-NOT COVERED BY MEDICARE Medically-necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN I
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[912]	$[912] (Part A deductible)	$0
61st thru 90th day	All but $[228] a day	$[228] a day	$0
91st day and after while using 60 lifetime reserve days	All but $[456] a day	$[456] a day	$0
91st day and after once lifetime reserve days are used – Additional 365 days	$0	100% of Medicare-eligible expenses	$0
91st day and after once lifetime reserve days are used – Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[114] a day	Up to $[114] a day	$0
101st day and after	$0	$0	All costs

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN I MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR			
*Once you have been billed $[110] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.			
SERVICES	**MEDICARE PAYS**	**PLAN PAYS**	**YOU PAY**
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[110] of Medicare-approved amounts*	$0	$0	$[110] (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (above Medicare approved amounts)	$0	100%	$0

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
BLOOD			
First 3 pints	$0	All costs	$0
Next $[110] of Medicare-approved amounts*	$0	$0	$[110] (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES-BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN I PARTS A & B			
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically-necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $[110] of Medicare-approved amounts*	$0	$0	$[110] (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
AT-HOME RECOVERY SERVICES NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a home care treatment plan			
Benefit for each visit	$0	Actual charges to $40 a visit	Balance
Number of visits covered (must be received within 8 weeks of last Medicare-approved visit)	$0	Up to the # of Medicare-approved visits, not to exceed 7 each week	
Calendar year maximum	$0	$1,600	

PLAN I OTHER BENEFITS - NOT COVERED BY MEDICARE			
SERVICES	**MEDICARE PAYS**	**PLAN PAYS**	**YOU PAY**
FOREIGN TRAVEL-NOT COVERED BY MEDICARE Medically-necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN J or HIGH DEDUCTIBLE PLAN J
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.
**This high deductible plan pays the same benefits as Plan J after one has paid a calendar year $[1690] deductible. Benefits from the high deductible Plan J will not begin until out-of-pocket expenses are $[1690]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1690 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $1690 DEDUCTIBLE** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[912]	$[912] (Part A deductible)	$0
61st thru 90th day	All but $[228] a day	$[228] a day	$0
91st day and after while using 60 lifetime reserve days	All but $[456] a day	$[456] a day	$0
91st day and after once lifetime reserve days are used – Additional 365 days	$0	100% of Medicare-eligible expenses	$0
91st day and after once lifetime reserve days are used – Beyond the additional 365 days	$0	$0	All costs

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1690 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $1690 DEDUCTIBLE** YOU PAY
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[114] a day	Up to $[114] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN J or HIGH DEDUCTIBLE PLAN J
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $[110] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.
**This high deductible plan pays the same benefits as Plan J after one has paid a calendar year $[1690] deductible. Benefits from the high deductible Plan J will not begin until out-of-pocket expenses are $[1690]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1690 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $1690 DEDUCTIBLE** YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[110] of Medicare-approved amounts*	$0	$[110] (Part B deductible)	$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (above Medicare approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $[110] of Medicare-approved amounts*	$0	$[110] (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN J or HIGH DEDUCTIBLE PLAN J PARTS A & B			
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically-necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $[110] of Medicare-approved amounts*	$0	$[110] (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
AT-HOME RECOVERY SERVICES - NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a home care treatment plan			
Benefit for each visit	$0	Actual charges to $40 a visit	Balance
Number of visits covered (must be received within 8 weeks of last Medicare-approved visit)	$0	Up to the number [#] of Medicare-approved visits, not to exceed 7 each week	
Calendar year maximum	$0	$1,600	

PLAN J or HIGH DEDUCTIBLE PLAN J OTHER BENEFITS - NOT COVERED BY MEDICARE			
SERVICES	**MEDICARE PAYS**	**AFTER YOU PAY $1690 DEDUCTIBLE** PLAN PAYS**	**IN ADDITION TO $1690 DEDUCTIBLE** YOU PAY**
FOREIGN TRAVEL-NOT COVERED BY MEDICARE Medically-necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
***PREVENTIVE MEDICAL CARE BENEFIT NOT COVERED BY MEDICARE** Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare. *** Medicare benefits are subject to change. Please consult the latest "Guide to Health Insurance for People with Medicare."			
First $120 each calendar year	$0	$120	$0
Additional charges	$0	$0	All costs

PLAN K
MEDICARE (PART A) – HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

You will pay half the cost sharing of some covered services until you reach the annual out-of-pocket limit of $4000 each calendar year. The amounts that count toward your annual limit are noted with two (2) asterisks (**) in the table below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided for in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[912]	$[456] (50% of Part A deductible)	$[456] (50% of Part A deductible)**
61st thru 90th day	All but $[228] a day	$[228] a day	$0
91st day and after while using 60 lifetime reserve days	All but $[456] a day	$[456] a day	$0
91st day and after once lifetime reserve days are used - Additional 365 days	$0	100% of Medicare-eligible expenses	$0
91st day and after once lifetime reserve days are used - Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[114] a day	Up to $[57]a day	Up to $[57] a day**
101st day and after	$0	$0	All costs

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
BLOOD			
First 3 pints	$0	50%	50%**
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	Generally, most Medicare eligible expenses for out-patient drugs and inpatient respite care	50% of coinsurance or copayments	50% of coinsurance or copayments

PLAN K
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

****Once you have been billed $[110] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $4000 per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges') and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[110] of Medicare-approved amounts****	$0	$0	****$[110] (Part B deductible)**
Preventive Benefits for Medicare covered services	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare-approved amounts	Generally 80%	Generally 10%	Generally 10%**
PART B EXCESS CHARGES (above Medicare approved amounts)	$0	$0	All costs (and they do not count toward annual out-of pocket limit of $4000)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
BLOOD			
First 3 pints	$0	50%	50%**
Next $[110] of Medicare-approved amounts****	$0	$0	****$[110] (Part B deductible)**
Remainder of Medicare-approved amounts	Generally 80%	Generally 10%	Generally 10%**
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN K PARTS A & B			
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically-necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $[110] of Medicare-approved amounts*****	$0	$0	$[110] (Part B deductible)**
Remainder of Medicare-approved amounts	80%	10%	10%
*****Medicare Benefits are subject to change. Please consult the latest "Guide to Health Insurance for People with Medicare"			

PLAN L
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

*You will pay one-fourth of the cost sharing of some covered services until you reach the annual out-of-pocket limit of $2000 each calendar year. The amounts that count toward your annual limit are noted with two (2) asterisks (**) in the table below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[912]	$[684] (75% of Part A deductible)	$[228] (25% of Part A deductible)**
61st thru 90th day	All but $[228] a day	$[228] a day	$0
91st day and after while using 60 lifetime reserve days	All but $[456] a day	$[456] a day	$0
91st day and after once lifetime reserve days are used - Additional 365 days	$0	100% of Medicare-eligible expenses	$0***
91st day and after once lifetime reserve days are used - Beyond the additional 365 days	$0	$0	All costs

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[114] a day	Up to $[85.50] a day	Up to $[28.50] a day**
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	75%	25%**
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	Generally, most Medicare eligible expenses for out-patient drugs and inpatient respite care	75% of coinsurance or copayments	25% of coinsurance or copayments**

PLAN L
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

****Once you have been billed $[110] of Medicare-approved amounts for covered services (which are noted with asterisk), your Part B deductible will have been met for the calendar year.

*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $2000 per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges') and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for he item or service.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[110] of Medicare-approved amounts****	$0	$0	****$[110] (Part B deductible)**
Preventive Benefits for Medicare covered services	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare-approved amounts	Generally 80%	Generally 15%	Generally 5%**
PART B EXCESS CHARGES (above Medicare approved amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of $2000)*
BLOOD			
First 3 pints	$0	75%	25%**
Next $[110] of Medicare-approved amounts****	$0	$0	****$[110] (Part B deductible)**
Remainder of Medicare-approved amounts	Generally 80%	Generally 15%	Generally 15%**
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN L PARTS A & B			
****Medicare benefits are subject to change. Please consult the latest Guide to Health Insurance for People with Medicare.			
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically-necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $[110] of Medicare-approved amounts****	$0	$0	$[110] (Part B deductible)**
Remainder of Medicare-approved amounts	80%	15%	5%**